SECTION OVERVIEW

This section describes the manner in which case records are composed, maintained, and expunged. This section also explores a person's access to records and case transfer procedures.

CHAPTER OVERVIEW

This chapter describes how records are established and maintained, as well as guidelines for inclusion of specific information.

1.1 RECORD COMPOSITION

Each family will have one record. This also applies to families with a child(ren) in out-of-home care, under the jurisdiction of the family/juvenile court, and placed in the legal custody and/or supervised by the Children's Division (CD).

If termination of parental rights occurs or family maintenance or reunification is no longer the case goal, a separate file for the child should be established. The new file is to contain any child specific information from the family file. Most of this information is contained in the child's section of the family record. Include in the new record any other pertinent information regarding the child such as the case narrative, court orders, Chaffee Independent Living information etc. Once a new file is established, maintain the record according to current case recording policy.

Following is the required outline for record organization for all families, including those with children in Out-of-Home Care and when family reunification is the goal. Use of this standard format will assist in record review when records are transferred across county lines.

The information contained in each record will be organized chronologically into the following sections. The cover sheet of each section will be color coded for quick reference.

1.1.1 CA/N Investigation Section – (Cover Sheet: Pink)

This section will include the CA/N investigation records that pertain to the household members. A child abuse/neglect investigation record contains information generated/obtained by the Division regarding a specific CA/N incident. A CA/N family record maintained on behalf of an individual may include one or more child abuse/neglect investigation records.

Specific guidelines and procedures exist for CA/N record information. When a Children's Service Worker receives a CA/N report through the CA/N Hotline Unit they shall establish a family record under the name listed as the #1 parent/substitute on the CA/N-1. If a family record exists for this individual and/or another parent/substitute in the same household, prepare one cover sheet "CA/N Investigation Section" for each reported incident of CA/N. The cover sheet should be on pink paper for quick reference. Label each cover sheet with the incident number. (Example: Investigation Record Incident # 01767001.) All hotline reports with findings of "Preponderance of Evidence" must be filed in the family record, if there is one.

All forms and documents related to the investigation of a specific incident should be filed in the following sequential order:

- CA/N-1, Child Abuse/Neglect Reporting form;
- CS-27 CPS Classification Screening;

- CPS-1, Child Abuse/Neglect Investigation/Family Assessment Summary form, and any supplemental narrative recording pages;
- CPS-1A, Safety Assessment (Part B), And CS-16D, Safety Reassessment (if applicable)
- Physical Examination Diagram (if applicable);
- Letters and/or release of information forms including the CS-30 Medical Information Request, the CS-31 Addendum to Memo to Medical Records Director, and the SS-6 Authorization for Release of Information;
- Documents and/or letters requesting and/or authorizing services (i.e., CS-67 and CS-67A);
- Evidentiary/collateral reports such as medical reports, school reports, psychiatric/psychological reports, police reports, written witness statements, transcripts of tape-recorded statements, and other reports or statements as appropriate;
- CS-21 CA/N Disposition Form Letter;
- CS-23 Report of Death or Serious Injury;
- Other material/forms collected and relevant to the investigation.

File all narrative recording and documents obtained/generated subsequent to the investigative conclusion and unrelated to the investigation in the family file sections other than “CA/N Investigation Section” or “Family Assessment” section.

The county designee (a Sup I or above) should provide only the “CA/N Investigation Section” to subjects or their designee who request to view the record, if the requesting person is someone other than the family member for whom the case file is maintained.

Related Subject: Chapter 2, of this section, Record Access.

1.1.2 Family Assessments Completed in Response to CA/N Reports – (Cover Sheet: Pink)

All forms and documents related to the investigation of a specific incident should be filed in the following sequential order:

- CPS-1 Child Abuse/Neglect Investigation/ Family Assessment Summary or Family Assessment Packet (CS-16)CPS-1A, Family Assessment (Part B) or Safety Plan (CS-16a);
- CS-16D, Safety Reassessment (if applicable)
- Family Plan for Change (CS-16b);
- Community Services Referral (CS-16c);
- CA/N-1 Child Abuse/Neglect Reporting form;
- CS-27, CPS Classification Screening;
- Physical Examination Diagram (if applicable);
- Letters and/or release of information forms including the CS-30 Medical Information Request, the CS-31 Addendum to Memo to Medical Records Director, and the SS-6 Authorization for Release of Information;
- Documents and/or letters requesting and/or authorizing services (i.e., CS-67 and CS-67A);
- Evidentiary/collateral reports such as medical reports, school reports, psychiatric/psychological reports, police reports, written witness statements, transcripts of tape-recorded statements, and other reports or statements as appropriate;
- CS-21a CA/N Disposition Form Letter; and
- Other material/forms collected and relevant to the assessment.

1.1.3 Assessment and Services Section – (Cover Sheet: Blue)

This section includes:

- A copy of the most recent SS-63 which is to be used as a face sheet;
- CS-16 packet, Family Assessment and Treatment Plan, the CS-16a, CS-16b, CS-16c, CS-16d, CS-16e and case narrative.
- CS-1 Case Plan and CS-1 attachment (only put CS-1 in this section if a separate record is being established for a child for whom reunification or family maintenance is no longer the goal. Otherwise the CS-1 is to be filed in the Child's Section of the family file.)

1.1.4 Child's Section – (Cover Sheet: White)

This section is created only if a child is placed in out-of-home care. Make a separate section for each child in out-of-home care. The Child's Section includes:

- Family/Child Health Assessment;
- Reports which relate specifically to the child, i.e., counseling, school, medical, etc.;
- CS-KIDS-1;
- CS-9 – Residential Treatment Referral;
- CS-66 SSI referral;
- A copy of the most recent SS-61 is to be used as a face sheet;
- Birth certificate;
- Social security card; and
- CS-1 and attachment (if applicable)

NOTE: A separate record is established for a child if parental rights are terminated or the goal no longer is reunification.

1.1.5 Correspondence Section – (Cover Sheet: White)

This section includes:

- Computer generated SEAS letters; and
- Letters sent/received through outside mail, excluding court-related and ICPC correspondence.
- Any information that the family requests to be included in the record should be filed in this section

1.1.6 Reports Section – (Cover Sheet: Green)

File all reports which are unrelated to investigations, or assessments, which were completed in response to CA/N hotline, and which are not specific to a child in Out-of-Home Care, such as:

- CTS reports;
- Educational reports;
- Medical reports;
- Psychiatric reports; and

1.1.7 Forms Section – (Cover Sheet: Canary Yellow)

File all forms (except ICPC forms, those related to the CA/N investigations, CS-1, and the Family Assessment Packet), such as:

- CS-32, Release of Liability;
- CS-40, Individualized Child Day Care Plan;
- CS-67, SEAS Request and Eligibility Form;
- CS-67A, SEAS Authorization Form;
  (Retain only the most recent turnaround of the CS-67 and 67A.)
- SS-6, Authorization for Release of Information;
- CS-99, Financial Statement for Parents of Children in Children's Division (CD) Alternative Care;
- CS-EAS-1, Emergency Assistance Services Request; and
- CS-IVE/FFP1, Title IVE-FFP Referral.

1.1.8 Legal Section – (Cover Sheet: Buff/Tan)

This section includes:

- Court orders;
- Court reports;
- Subpoenas;
- Summons;

- Petitions;
- Depositions;
- Court-related correspondence;
- Written Service Agreement (if the court requires this in addition to the Family Plan for Change).

1.1.9 ICPC Section – (Cover Sheet: White)

All ICPC related forms and correspondence should be included in this section.

1.1.10 Administrative Review Section – (Cover Sheet: White)

Documentation of all local and area reviews should be included in this section.

1.1.11 Intensive In-Home Services Section – (Cover Sheet: White)

All Intensive In-Home Services related forms and correspondence should be included in this section.

1.1.12 Domestic Violence Section – (Cover Sheet: Red)

This section includes:

- Orders of Protection;
- Police Record;
- Written Statements;
- Witness Statements;
- CPS-1, (Safety Assessment Section), CPS-1A, Safety Assessment (Part B), CS-16 D, Safety Reassessment; and
- Narrative summary of violent incidents.

1.1.13 Chafee-Independent Living Section – (Cover Sheet: White)

This section is to contain any referrals, assessments, forms or other information specifically related to Chafee-Independent Living Services which includes CHOICES, Independent Living, and Aftercare. This section should include all Chafee information for all youth in the family who are receiving these services. If

a separate file has to be established for a child receiving Chafee services, the child's file needs to contain that child's specific Chafee information.

- CS-ILP-1A, Independent Living Program Referral;
- CS-3, Life Skills Inventory;
- CHOICES Life Skills Pre-Assessment;
- CHOICES Life Skills Post-Assessment;
- Daniel Memorial Institute Individual Living Assessment for Life Skills;
- CS-ILP-4, Chafee Foster Care Independence Program Support Application;
- CS-ILP-3, Invoice for Youth Skills Training.

1.1.14 Adoption/Guardianship Subsidy File - (Separate File Folder)

This file is to contain family adoption/guardianship subsidy information and should be created for the adoptive or guardian family at the time of their first adoption/guardianship involving subsidy. As the family adopts or receives guardianship of more children, the new children's information is to be added to this file. This is to be a separate file used by the Children's Service Worker managing the subsidy. Any information post-adoption/guardianship should be placed in this file. Contents of this file are to include the Child's Placement summary, any reports for the child, the family's home study and updates, forms , payment related paperwork, legal paperwork, the subsidy contract, any narrative that may be related to the family, and any correspondence. The following sections are to be a part of this file:

- Child Assessment – (Cover Sheet – White)
  - Child placement summary signed by the worker and family
  - Reports on the child
- Family Assessment - (Cover Sheet – White)
  - Home Study
  - Updates
- Forms – (Cover Sheet – Yellow)
  - SS-61
  - SS-60
  - ICAMA
  - TPL
  - Title IV-E FFP2
  - Release of Information
  - KIDS-2

- Payment – (Cover Sheet – Green – to be retained for at least one year. If needed, the computer system retains this information and can be obtained.)
  - SEAS
  - SS-65
  - Receipts

- Legal – (Cover Sheet – Buff/Tan)
  - In LG Cases – Proof of Children's Division Custody
  - Court orders:
    - Release of Jurisdiction (Adoption only)
    - Adoption Petition – (if the worker receives one)
    - Transfer of custody order
    - Adoption decree

- Subsidy Contract – (Cover Sheet – Pink)
  - Adoption and Guardianship subsidy forms

- Narrative – (Cover Sheet – Blue)
  - Begin with the date the family is identified as the adoptive resource for the child
  - Initial meeting regarding subsidy and the child's future needs
  - Transfer summaries
  - Ongoing narratives as contacts ensue

- Correspondence – (Cover Sheet – White)
  - Annual review letter
  - Fair hearing review letter
  - Any other written correspondence

NOTE: This record should be used when completing Peer Record Reviews of Adoption cases.

1.2 Recording Guidelines

1.2.1 Definition, Purpose, Style

The family record shall summarize social work activity, including family strengths, efforts to address safety and risk issues, a summary of the activities of any treatment agents and/or family support teams. The record must also include the family's involvement in and reaction to services provided.

The guidelines listed below are intended to provide a basic structure for capturing relevant information. They are designed to serve as a general framework for all recording. Emphasis is placed on being purposeful, specific, factual, and focused on the investigative, assessment and/or treatment process. The

Children's Service Worker and supervisor are free to modify certain components, when appropriate, in order to accommodate the needs of specific situations.

The Children's Service Worker's use of "I" (first person pronoun) is preferred when describing his/her activities. This conveys a sense of ownership and accountability. Avoid using third person descriptors, such as "worker" for this purpose.

1.2.2 Recording Guidelines – Investigations

All CA/N investigation narrative recording is done on the CPS-1 and supplemental pages. Handwritten notes should be destroyed. Handwritten notes should only be maintained as part of the record if they are necessary as evidence to either substantiate or unsubstantiate abuse/neglect. Any information maintained is subject to subpoena and the Children's Service Worker should keep this in mind when completing the investigation. Narrative recording serves as a means for the worker to document all investigative activities. It also assists the worker in making decisions by:

- Enhancing communication between the worker and supervisor;
- Serving as documentation of the worker's decision; and
- Gathering all information in one place to facilitate decision-making.

The investigative record aids the Children's Service Worker in planning for and conducting the investigation. In addition, it provides valuable information to staff who are subsequently assigned to provide services to the family. Thorough narrative recording will also demonstrate compliance with agency policy and legal mandates.

The purpose of narrative recording of CA/N investigations is to:

- Provide a chronological list of all the investigator's activities related to the investigation;
- List the facts and direct observations obtained by the investigator during the investigative process; and
- List the evidence that supports the facts.

To accomplish these objectives, the narrative must be thorough, accurate, clear, specific, timely, and factual.

1. THOROUGHNESS:

   The investigator must secure and record all information necessary to make critical decisions affecting the conclusion. Narrative recording is

thorough when it answers the following questions for the reader: who, what, when, where, why, and how the incident occurred. Some information, particularly the law enforcement/prosecution section, may not be available to staff when the investigation is completed. Update the information at a later time, as the information becomes available.

2. ACCURACY:

Descriptions of observations, physical evidence, and statements must be recorded with accuracy and in detail. The following is a seven-point review, which is a good test of the accuracy of narrative recording:

- Is the data contained in the recording accurate;
- Is the data contained in the recording complete;
- Are there persons or places in the report for which full identifiers are not given;
- Are the times and dates of events present;
- Are the events described in the recording understandable in that they are in proper sequence and the chronology is clearly set forth;
- Are all articles of evidence, whether obtained by worker or others, identified and their location given;
- Can the reader tell from the report the relevance of each item of data that has been presented.

3. BREVITY:

Effective writing is concise. Narrative recording should contain no unnecessary words or sentences. Lengthy run-on sentences only confuse the reader. Short declarative sentences convey information more efficiently.

4. SEPARATING FACTS FROM JUDGMENTS:

It is important that the Children's Service Worker separate facts from judgments made about those facts. This separation encourages the worker to detail facts of the investigation before forming judgments. The facts should support the judgments rather than vice versa.

When forming and recording professional judgments, the Children's Service Worker should be extremely cautious with "labeling" terms. The

worker should avoid the use of psychological or medical diagnosis which he/she is not qualified to make when describing a condition/behavior.

5. TIMELINESS:

Timeliness in recording information is important for two major reasons:

- The sooner the information is recorded, the more accurate it is likely to be;
- For information to be introduced as evidence in a court hearing, records must:
  - Be made during the regular course of the investigation;
  - Be made at or near the time the event(s) occurred; and
  - Be recorded by someone who has knowledge of the event(s).

6. DISCUSSIONS WITH THE DIVISION OF LEGAL SERVICES:

Discussions with the Division of Legal Services (DLS), including the name of the DLS attorney, dates of discussion or options discussed, should not be documented in the record as this waives the right to attorney/client privilege. Rather, the narrative should reflect the decision reached by the Children's Service Worker after discussions with DLS. If there would normally be an entry in the narrative concerning social work activity following a discussion with DLS, that entry may indicate a contact with DLS, but must not be specific with regards to content or options/recommendations discussed.

If the Children's Service Worker desires to retain the content of the entire discussion, this information should be retained in a separate file in the county director or supervisor's office. Information retained in a separate place is not subject to release or subpoena.

1.2.3 Policy Requirements Related to Narrative Recording

For consistency throughout the state, narrative recording must, at a minimum, follow the guidelines and format described in this section. Exceptions to these methods require supervisory approval and will be limited to rare situations.

Case contacts and activities shall be summarized in the case narrative:

- At the conclusion of the assessment process in the form of an opening summary.
- At least every thirty (30) days following the initial assessment and initiation of the treatment plan;
- Quarterly following the initial assessment and initiation of the treatment plan;
- Upon transferring an open case to another worker or county;
- At the conclusion of the treatment plan; and
- At closing of services to family.

More frequent entries may be utilized if warranted.

To ensure legibility and a business-like appearance, all case narratives shall be typed. Case narrative entries are to be signed and dated by the worker as indication that narrative entries are accurate.

Information referring to unsubstantiated CA/N investigations shall not be included in the family record.

Unsubstantiated reports and family assessments (when a family is not opened for services) should be filed so that staff can quickly access the record.

Unsubstantiated reports are retained in the county that completed the investigation. The county completing the investigation will receive the expungement list for the unsubstantiated report. Unsubstantiated reports are not transferred to another county with open family records.

NOTE: The date of expungement, if unsubstantiated, must be noted at the time investigation is completed, if there will be no record opened as a result of the investigation.

1.3 Recording Guidelines - Family Assessments (Ongoing Work With Families)

Instructions for this section describe how the Children's Service Worker is to maintain a written account of social work activity.

Initial family assessments are completed using a CPS-1 and CPS-1A. For ongoing work with a family, the Children's Service Worker will complete the CS-16, Family Assessment Packet or to a copy of related portions of that packet.

In addition to the Family Assessment Packet, it will be necessary to utilize the following recording guidelines to organize the massive amounts of information sometimes assembled by the Children's Service Worker.

Case narrative recording refers to the written documentation compiled and included in the case record to describe casework activity. This documentation will be written in a specific format that includes the following elements; an **opening summary**, a **case contact summary,** a **monthly progress summary,** a **quarterly reassessment summary,** a **closing summary** (when terminating services), and a **transfer summary** (when transferring an open case to another worker or county).

These narrative elements are defined below and are used to document the Children's Service Worker's efforts to address and eliminate the problem behaviors placing child(ren) at risk of abuse or neglect.

- **Opening Summary**: a brief descriptive summary used when opening a case. This should include the reason for case opening as well as any other pertinent information not already included in the CS-16.

- **Case Contact Summary**: a monthly chronology of contacts made during the course of service provision.

- **Monthly Progress Summary**: a treatment-focused summary done monthly to summarize progress made towards treatment goals.

- **Quarterly Reassessment Summary**: a treatment-focused reassessment summary done each quarter to summarize activities over a 3-month period. It summarizes the activities of the worker, family, Family Support Team and/or service agents and should detail the family's reaction and response to the services provided as well as whether service goals have been achieved or not.

- **Transfer Summary**: a summary of case activity up to the point of case transfer.

- **Closing Summary**: a summary completed when terminating services to a family.

1.3.1 Initial Recording

OPENING SUMMARY
An opening summary begins the initial case narrative recording, after the completion of the Family Assessment and Treatment Plan (CS-16). This should include the reason for case opening, in addition to any relevant information that pertains to the family's presenting and underlying problems if this information is not clearly described in the CS-16. The Opening Summary should not replicate information already contained in the CS-16, but may supplement and expand on the descriptive information contained in this packet if needed.

Example: Case opened due to substantiated report of physical abuse to Billy Jones by his biological father. Safety of child was assured as Mrs. Jones is now living with her sister and does not have contact with Mr. Jones at this time. Mrs. Jones has requested assistance in procuring housing and counseling for herself and Billy.

Related Subject: Chapter 1.3.5, of this section, Subsequent Recording Outline.

1.3.2 Subsequent Recording

Subsequent (on-going) case narrative recording is composed of a monthly **Case Contact Summary,** a **Monthly Progress Summary** a CS-16e, Risk Reassessment and a **Quarterly Reassessment Summary**. These elements must focus on observable changes occurring during the treatment process. They must summarize and record the Children's Service Worker's pertinent observations regarding the case contacts.

- A **Case Contact Summary** must be done at least every 30 days following the assessment and initiation of the service plan.
- A **Monthly Progress Summary** must be done at least every 30 days following the assessment and initiation of the service plan to determine and document progress towards treatment goals.
- The **Quarterly Reassessment Summary** must be done every 3 months (quarterly) to determine if case goals have been met and whether case should remain open or not.

All narrative recording must be signed and dated by the worker as indication of accuracy and accountability.

1.3.3 Subsequent Recording Outline

Case Contact Summary – a monthly chronology of contacts made during the course of service provision which includes:

- Date of contacts;
- Persons contacted;
- Contact type and origin: Indicate the nature of the contact, that is, by phone, personally, by letter, etc. Use "made," "sent," or "received," to indicate the origin of phone calls and letters;
- Location of contact: Indicate the location of the contact if it was a personal contact;

- Purpose of contacts: Give a brief explanation of the purpose of each contact or what it intended to accomplish; and

- Result of Contact: Describe information obtained during contact when it is pertinent to the treatment process or changes occurring in the family system. Include the family's reaction and response to contact if applicable.

- Contacts included but not limited to:

    - Consultation conferences with supervisor

    - Consultation with any external consultants

    - Family Support Team meetings

    - Court hearing (type of hearing, who present and the outcome or order of the court)

    - Mail sent and received

    - Certification for CTS, day care, etc.

    - Date forms completed (SS-61, 63, etc.)

    - Date and type of any review done on the case record (Peer Record Review, Program Development Review, etc.)

    - Home visits

    - Telephone calls

Case Contact Summary Example:

02-28-00 / Mrs. X / personal / in-home / discussed parent aid visits. Mrs. X stated the parent aid has assisted her with budgeting for the household and Mrs. X is eager to get into her own place.
03-03-00 / Mr. X / phone call made / discussed Mr. X entering treatment facility
03-04-00 / Mr. X / phone call received / Mr. X has made appointment for 4/10/00 for substance abuse evaluation. Mr. X stated he is anxious to get the evaluation done so he can begin treatment;
03-15-00 / TC from school counselor / Billy has not been to school for a week. School is getting no response from Mrs. Jones.
03-16-00 / Tom Smith, M.D / letter sent / SS-6 sent with request for information;

NOTE: A separate contact summary preface should not be needed in chronological recording if all of this information is contained within the date specific entry.

Monthly Progress Summary- A monthly service-focused summary that follows the case contact summary. It summarizes the progress, or lack of progress, being made towards established service goals.

Monthly Progress Summary Example:
Mrs. X is making progress towards her goal of establishing her own household by working on a budget with the parent aide. Mr. X continues to work towards his goal of maintaining stable employment as he has set an appointment for a substance abuse evaluation so that he may enter a treatment facility next month. There is an apparent lack of progress regarding Billy's goal of regular school attendance as it has been reported that he has missed at least one week of school. This worker will follow-up with family to determine the nature of Billy's absences.

Quarterly Reassessment Summary- A service–focused summary that describes the pertinent information obtained during the case contacts during the last quarter. Use behavioral descriptions where possible to accurately summarize and illustrate the observed changes taking place in the family system. Record the family's reaction and response to services provided. Complete a CS-16e, Risk Reassessment. The decision to continue services or close the case should be staffed with the immediate supervisor and briefly documented on the reassessment portion of the CS-16.

Briefly summarize the outcome or consequences of the treatment services provided to date. Describe how treatment services have changed the underlying sources of family dysfunction that may have led to the presenting problem. Address issues such as:

- changes in the observed risk;

Related Subject: Section 2 Chapter 5.5.5 Assessment of Risk

- Changes that are observed in the presenting problem(s). Describe these changes using an individual and systems viewpoint;
- changes in resource usage and interaction with outside systems; and
- Changes in the service strategy for the next 90 day if services are to continue.

Quarterly Reassessment Summary Example:
During the last 3 months the X family has continued to be committed to working on the case plan. Mr. X did complete the evaluation for the alcohol

assessment and although hesitant to do so, related to this worker that he feels committed to entering a treatment program. Mr. X encouraged his wife to continue counseling and she, in turn, has shown some efforts in asserting herself. In a private conversation with Ms. X, she indicated that she is apprehensive about counseling as she now has to face problems that have not been discussed before. Billy continues to make satisfactory progress in school and his attendance has been perfect in the last quarter. Service strategy is to provide support to Mr. & Mrs. X as Mr. X enters his treatment program and seeks to gain stable employment. Mrs. X to continue in individual counseling to deal with domestic violence issues. The CS-16E Risk Reassessment shows the family's risk has been reduced from high risk to moderate risk. Will continue monitoring Billy's school progress.

The quarterly reassessment summary is to be documented in the case narrative. Additionally, the reassessment portion of the CS-16 should be completed to indicate whether the case should remain open for services or not, then submitted to the immediate supervisor for review and signature.

Case Transfer Summary: In the event a child or family moves from the county of jurisdiction, a transfer summary must be completed within 10 days by the worker in the case managing county prior to transfer of case record. The transfer summary should include:

- Reason for opening and reason for transfer;
- Current status of child and family with regard to established goals;
- List of upcoming appointments as well as with whom they are scheduled (e.g. upcoming FST meetings, medical appointments, court dates etc.);
- Visitation plan if applicable;
- Any other information pertinent to the case that is necessary for optimal service delivery to the family.

Transfer Summary Example:

On 2/24/2001 a case was opened as a result of a substantiated report of educational neglect and substandard living conditions in the home. On 4/1/00 the entire family is moving to an adjoining county where they have procured housing closer to Mr. Jones's place of employment. Family will continue with parent aide services on a weekly basis to assist them towards goal of learning appropriate housekeeping skills. Billy Jones will continue with IEP in his new school in order to achieve his goal of advancing to the next grade level. Billy has an appointment on 3/15/2001 with Dr. Jones (573-999-6666) for a psychological evaluation.

The transfer summary should be submitted to the immediate supervisor for review and signature.

Closing Summary: This summary is done within 30 days of terminating services with a family. The closing summary should include:

- Reason for opening;
- Current status of child and family including safety status of child;
- Justification for case closure which should include behaviorally specific description of how the family has stabilized and achieved the goals in the original or updated case plan;
- Family reaction to termination of services;
- Community referrals made by worker to support family after case closure;
- Any ongoing aftercare services the family will be receiving (e.g., continued counseling).

The closing summary should be submitted to the immediate supervisor for review and signature.

1.3.4 Treatment-Focused Summarized Recording

A vast collection of information, unless required for legal purposes, tends to inhibit an accurate reflection of treatment. It requires others to weigh and interpret information in order to glean important facts. Treatment-focused summarized recording, on the other hand, reduces the amount of peripheral information in order to focus staff on the family's progress and treatment.

Since the Children's Service Worker's efforts to improve family functioning must be guided by a precise recognition of the presenting problems and specific unacceptable behaviors to be modified, as well as the strengths of the family, the ongoing narrative should focus on clear, behavioral definitions of the current problems to be addressed. Focusing on specific behaviors is essential if the worker is to respond appropriately to the family system's evolving character, needs and priorities. The narrative must describe strategies for resolving these problems.

As no record can accurately reproduce everything that is said and done, the Children's Service Worker must sift out and select items of information which he/she thinks are of the greatest significance. Generally, the narrative should not include all that happened during any one interview, conference, or time period. Treatment-focused summarized recording briefly describes what took place between the worker and family or collateral. It should summarize events based upon the worker's evaluation of their significance to the treatment process.

Omit excess material and communicate only the important activities and events relating to the treatment process. Carefully appraise the facts pertaining to the reasons for Division involvement with the family and the family's reactions to treatment and intervention and record only information that is essential to an understanding of the family system and its dysfunction.

Treatment-focused summarized recording is useful to describe ongoing trends, progress, or regression, within a certain time period (i.e., 30 days). Topical headings may be used to further organize the content of events, which occurred within the time period.

The following guidelines will assist in the preparation of treatment-focused summarized recording. The Children's Service Worker should:

- Keep complete and accurate notes by date in a notebook/pad so meaningful material can be selected for the record;
- Evaluate and organize the material before recording it. Identify items that pertain to the treatment process;
- Omit unnecessary and repetitious words;
- Avoid lengthy explanations or detailed accounts of activities that do not focus on the treatment process. Activities such as searching for a record or attempting to reach someone by phone do not require much attention;
- Describe people in a few words with clarity. Recognizing the significance of their appearance and behavior is important. Lengthy description of an individual for the sake of description is not purposeful;
- Avoid repetition. Even when there is a change of Children's Service Workers, there is no need for repeating information already in the record; and
- Pay particular attention to items that may be critical in court testimony.

Summarized recording may be used whether information is organized in a chronological manner or by topical headings.

1.3.5 Chronological and Topical Headings

Chronological recording organizes and describes case activities by the specific date of occurrence. Chronological recording is useful if the Children's Service Worker is anticipating court action and the specific daily actions of a client need to be documented.

When organized chronologically, the Worker shall record only the pertinent events deemed critical that occurred on a specific date.

Topical Headings - Topical headings may be used if the Children's Service Worker feels the need to highlight certain significant events or observed changes within the recording period. This method should be used in conjunction with a chronological contact summary, which includes a description of the purpose of the contacts.

Refer to the subject areas listed below. Address the following areas in the narrative entry **only as needed** to further describe pertinent observations:

a. **Family System Dynamics** - Use the following headings as needed to describe changes in the family system dynamics since the completion of the assessment or since the previous narrative entry.

1) **Family System Composition**: Describe the changes in the family system's composition since the assessment was completed, or since the previous narrative entry. If the family structure changes significantly, the Children's Service Worker should diagram the family again. This should be included within the body of the case narrative.

2) **Internal Family Interaction**: Describe observable interaction between family members, such as:

- Observable changes in roles, such as leadership role(s) and power position(s);
- Role conflicts which are identified;
- The level of cooperation between family members; and
- Recreational interests or pastimes.

3) **Family Interaction with Outside Systems:** Describe the changes in the interaction of the family system with outside systems since completion of the assessment or since the previous narrative entry. Address areas such as:

- Employers
- Police
- Church
- Neighbors
- Health care system
- Babysitter
- Schools
- Extended family
- Children's Service Worker
- Family Support Team members

4) **Collateral Information**: Document significant collateral information that has been obtained since completion of the assessment or previous narrative entry.

b. **Physical and Behavioral Observations** - Describe relevant observations relating to the family's environment or to the family members.

1) **Physical Environment**: Describe changes in the family's physical environment since completion of the assessment and initial entry, or since the previous narrative entry. Address areas such as:

- Housekeeping standards;
- Home/property condition;
- Neighborhood condition;
- Utilities;
- Relocation of residence.

2) **Changes in Health, Physical Appearance, and Behaviors**: Describe relevant observations regarding each family member since completion of the assessment and initial narrative, or since the previous narrative entry. Address areas such as:

- Health;
- Physical appearance (bruises, clothing, hygiene); and
- Noteworthy behavioral changes.

c. **Treatment Issues** - Describe observable changes relating to the treatment issues. Use behavioral descriptions where possible to accurately illustrate changes observed during the treatment process, since completion of the assessment and treatment plan, or the previous narrative entry. Address issues such as:

1) **Presenting Problems**: Describe changes in the presenting problem(s) since the assessment or previous narrative entry.

- Has the frequency and/or intensity of the problem behavior(s) changed;
- Has the problem behavior(s) become more or less serious;

- Why the problem behavior(s) has changed.

2) **Family's Response to Presenting Problems**: Describe changes in the reactions of the family to the presenting problem(s) since the assessment or previous narrative entry.

- Has the function of the presenting problem (symptom) been changed;

- Family members' understanding or perception of the presenting problem(s);

- Increased or decreased coping skills.

3) **Additional Problem Behaviors**: Document whether additional problem behaviors have developed since the assessment or previous narrative entry. If they have, provide:

- An accurate description in behavioral terms; and

- An opinion on why the new problem behaviors have surfaced.

1.4 Recording Guidelines – Out-of-Home Placement

Instructions for this section describe what and how, the Children's Service Worker is to record when an out-of-home placement has occurred.

1.4.1 Initial Recording

1. The Children's Service Worker should identify reason(s) for removal and the date of removal.

2. If there have been preventive and protective services, specify why the written service agreement developed with the parents failed to prevent placement, or document the reasonable efforts to prevent placement in an emergency placement.

3. In the case plan, the Children's Service Worker should state the specific placement plan, such as "temporary foster care – goal to return child to birth parents." Address the following specific components of the case plan:

   - Child's Progress

     Describe the out-of-home placement and provide details of the appropriateness of the placement such as:

- Is the child getting proper care;
- Is the child in the least restrictive placement environment and in proximity to the birth family? If close proximity is not advisable, explain. Provide reasons a relative placement is not advisable;
- Are appropriate services being provided to the child, and the foster parents;
- What are the child's needs and are they being met; and
- What is the child's present health or what are the child's health needs.

- Parental Progress
  - Are they receiving services;
  - Are these services appropriate;
  - Is the parent(s) cooperating; are they making progress;
  - What is the frequency of the visitation schedule. Are the parents participating. Interacting with the child during visits;
  - Are the parents providing child support;
  - What is the status of the parents' compliance with the Written Service Agreement; and
  - What are the efforts to locate absent parents, if applicable.

- Coordination of Services
  - Are services to the child, the foster parents, and birth parents coordinated toward a specified goal;
  - Are services being provided in accordance with the recommendations of the Permanency Planning Team; and
  - Are plans/services appropriate to the long-range permanency treatment plan, court order and/or special court instructions.

The Children's Service Worker should identify that the rights of the parents were safeguarded. He/she should identify the date that the procedural safeguards and parent's rights were provided to and discussed with, the parents regarding the removal of the child. The

worker should also document that the procedural safeguards were given to the parents regarding intended changes in placement and/or visitation. If this was not done, explain.

The Children's Service Worker should identify the service plan and outline the next steps in the provision of services to be directed toward the return of the child or other permanent plan. The worker should then project the next review date.

1.4.2 Interim Recording

All contacts shall be recorded chronologically in the narrative section of the family record. Chronological dictation will include the date, time, person(s) contacted, and a description of the content of the communication. Contacts include:

- All personal contacts such as home visits, office visits, and telephone calls;
- Conferences with supervisors regarding specific family situations;
- Court hearing information such as the type of hearing, persons present, and the outcome of the hearing;
- Permanency Planning Team meetings, including the date parents and foster parents were notified, those present, and the PPT recommendations;
- An indication of the date when the CS-1 was completed and sent to court;
- All correspondence sent and received;
- Documentation of the need for purchased services such as day care and Children's Treatment Services and all referrals that have been completed and all services authorized;
- The date the SS-60 and the SS-61 were submitted for an opening, a closing, or an updating of the case situation;
- An evaluation of the progress made toward achieving a permanent plan.

1.4.3 Assessment of the Case Plan in Initial and Interim Recording

The Children's Service Worker will include in the case plan review the following:

- An evaluation of the child, parents, and foster parents' progress in completing the case plan;
- An assessment of the appropriateness of the services being provided to the child, such as counseling, medical, educational, and day care services;
- A description of how these services are meeting the specific needs of the child;
- An assessment of how the services provided are meeting the needs of the parents;
- A description of how the terms of the Written Service Agreement and/or court approved service plan are being met by the parent, the child, and the worker;
- A description of the child and foster parent's involvement in the development of the services and visitation plans. This will include narrative on how these plans are beneficial to meeting the goal of permanence for that child.

The Children's Service Worker will include in the projected plan for the next three months the following:

- A description of the services which need to be provided to achieve reunification;
- An outline of who will provide these services; and
- The frequency of worker's contacts with the family, and the frequency of parent-child visitation.

1.4.4 Documentation of Discussion With the Division of Legal Services

As stated in 1.2.2, regarding investigation documentation, discussions with the Division of Legal Services (DLS) should not be documented in the case record. See that section for further clarification and information about where content of those discussions or documents may be retained.

1.4.5 Documentation of Information Regarding Domestic Violence

The disclosure and documentation of domestic violence may dramatically increase the risk of harm to the child and adult victim. Therefore, any specific information disclosed by the child or adult victim that is requested to be kept in confidence shall be. However, it is imperative to share with the family up front

that all issues compromising the safety of the child will be addressed openly. Consultation with a supervisor on making this distinction is recommended.

Documentation of instances of domestic violence and any collateral information to back up the allegations (order of protection, police reports, witness statements, etc.) shall be kept in the domestic violence section of the file that will be marked by a red cover page. This section will not be released to the domestic violence offender. If this information must be shared per court order, the adult victim should be notified in advance so that he/she may consider safety plans.

MEMORANDA HISTORY: CS03-51, CD04-45; CD04-79